Does family psychoeducation have a future?

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When Carol Anderson and I sat down in 1977 to construct what we called "family psychoeducation" (1), three recent and compelling publications had convinced us that an alternative to traditional family therapy was an idea whose time had come. Hirsch and Leff had failed to find convincing evidence that parental behavior contributed to the etiology of schizophrenia (2). Shortly thereafter, Vaughn and Leff (3) offered a striking confirmation of the observation that the attitudes of close relatives could drive the course of already affected individuals in a positive or negative direction, a construct that has subsequently been extended to other disorders and non-familial relationships. At the same time, we were aware of the new Goldstein study which convincingly showed that a brief, 4 session, untraditional problem solving approach to the family's management of illness could, in the context of appropriate medication, dramatically lower short-term relapse rates (4). We were thus encouraged to develop a theoretically driven approach that hypothesized a long-term reduction in the traditional high relapse rate for schizophrenia, if only the 'emotional temperature' of the home environment could be lowered, thereby decreasing the demands on patients who might have a limited information processing capacity (5). Beyond its 'stress management' components, the approach required a then unfamiliar 'alliance' with the family, the teaching of day to day survival skills, and a collaborative stepwise plan for reintegrating the patient into family and community life. The family's common emotional responses to schizophrenia were addressed (denial, fear, guilt, frustration, anger and hopelessness) along with attempts to improve communication and problem solving skills. Coping strategies that could counter the family's unhelpful attempts to normalize or ignore psychotic behavior (and the needs of other family members) were introduced. Research support was received from the National Institute of Mental Health (NIMH) in 1978 and ultimately the results among 103 patients and families, treated for 2 years, exceeded our expectations (6,7). We never envisioned the worldwide research effort that developed. In an impressive attempt to summarize the results of these diverse investigations, Falloon has clearly shown that family psychoeducation, when combined with antipsychotic medication, possesses a prophylactic efficacy against relapse that is at least twice that of medication and support.

So why is it (in North America at least) that few families of the severely mentally ill have ever been offered family psychoeducation (8), despite a quarter century of replications? Even among the rare families that are engaged, most appear to receive an occasional lecture or 'bibliotherapy', but not one of the evidence based family approaches. Dixon et al (8) have identified a myriad of policy and organizational obstacles to implementation, including staff burdens, cost, skepticism, philosophical differences and lack of leadership. Obtuse, post-modernist formulae now proclaim the need for a multi-disciplinary industry comprised of organizational, systems and learning theorists, decision making analysts, and information scientists in order to implement novel behavioral interventions (9). However, the facts speak to a more narrowly drawn reality: the absence of a dedicated funding source.

I have long felt that many mental health leaders, who in some parts of the world have abrogated treatment policy to the 'managers' of care, have been adversely influenced by a tradition of therapeutic nihilism regarding the psychosocial treatment of schizophrenia. Even the least costly treatments, such as Goldstein's approach (4), are rarely if ever implemented. In the hands of managed care administrators, however, mental health expenditures as a percent of all health care costs have fallen dramatically in recent years (10). The criterion of 'medical necessity' (a culturally defined value judgment) has limited patient access to the more efficacious albeit costly treatments. Only 10% of the severely mentally ill patients, for example, have access to psychosocial rehabilitation programs in the US. Insurance reimbursement, the most feasible funding source for psychosocial treatment in the US, is uniformly biased against the severely mentally ill (11). Mechanic and McAlpine warn the purchasers of these low cost products that the severely mentally ill will be the least likely to enjoy technological advances in treatment (11). In brief, there seems little hope for the implementation of efficacious psychosocial treatments, including family psychoeducation, without a dedicated funding source at the national and/or local levels. (Once funds are available, even the most nihilistic mental health leader will likely become an enthusiastic advocate of family psychoeducation.)

What we do not need at the moment are more efficacy studies designed to silence the skeptics. A colleague once remarked (quoting his mother's developmental advise) that 'maturity is knowing when enough is enough'. Most remaining questions about family psychoeducation are the artifacts of poorly designed studies.

Family psychoeducation is a stabilization phase intervention, and the psychosocial treatment studies of schizophrenia (12) [or affective disorder (13)] that rule-out symptomatically unstable patients from maintenance treatment have not and will likely never be able to demonstrate an effect on relapse (or on adjustment, since poor functioning is often the mirror-image of relapse). Research replications have had little effect on implementation. The most widely implemented, but least replicated, psychosocial treatment for schizophrenia is 'supportive psychotherapy' (14). In the absence of demonstrated efficacy, 'support' is nevertheless the least expensive intervention to provide because managed care systems rarely require the provider credentials that increase cost. (New medications become quickly implemented, not because of replications among more representative users, but because of an enormous, dedicated marketing resource).

Other efficacious, patient oriented, stabilization phase interventions now complement family psychoeducation (15-17). More importantly, the field is moving to develop cognitive rehabilitation strategies that target the social and vocational disability of otherwise symptomatically stable patients who are in the recovery phase (18). We have recently suggested a cost effective treatment algorithm that attempts to integrate these evidence-based practices, both family and patient centered, as well as individual and group approaches (19). Most patients and families have clear treatment requirements and preferences that can be flexibly accommodated.

What world psychiatry does need is a vocal and influential advocacy for the public and/or private funding of evidence-based psychosocial treatments that have demonstrably lowered morbidity and increased functioning and quality of life for the severely mentally ill. The future of family psychoeducation, and other phase-relevant interventions, is entirely dependent on it.

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